DEPARTMENT OF THE ARMY
HEADQUARTERS, U. S. ARMY MEDICAL COMMAND
2050 WORTH ROAD, SUITE 10
FORT SAM HOUSTON, TEXAS 78234-6010

REPLY TO
ATTENTION OF

MCHO-CL-P (40)

16 JUN 1999

MEMORANDUM FOR Commanders, MEDCOM RMCs/MEDCENs/MEDDACs

SUBJECT: Management of Patients in Observation Status

1. References.

a. Memorandum, Tricare Management Activity, Office of the Assistant Secretary of Defense (Health Affairs) (OASD(HA)), 17 March 1999, subject: Interim Policy for the Reporting and Billing of Observation Care Services.

b. Memorandum, Tricare Management Activity, OASD(HA), 7 July 1998, subject: Department of Defense Observation Services Definition.

2. Purpose. This memorandum provides guidance for implementation of an interim policy for the reporting and billing of observation care services; and procedures for managing patients in a non-admitted observation status. The requirements identified in this document must be incorporated into standing operating procedures of military treatment facilities (MTFs) providing care to patients in observation status.

3. Scope. This policy applies to all U.S. Army Medical Command MTFs providing care and treatment to patients in an outpatient observation status.

4. Definition.

a. Observation services are those services furnished by a hospital [the term "hospital" includes Department of Defense (DOD) clinics with resources to provide these services] on the hospital premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are

reasonable and necessary to evaluate an outpatient's condition or to determine the need for a possible admission to the hospital as an inpatient. Such services apply to observation patients only when provided by order of a physician or another individual authorized by hospital medical staff bylaws to admit patients to the hospital or to order outpatient tests. Most observation services do not exceed 24 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified.

b. Observation patients may be cared for in either dedicated observation units or in designated bed space on inpatient units. Appropriate Joint Commission on Accreditation of Healthcare Organizations (JCAHO) standards will apply to the care and management of the observation patient.

5. Placement in observation status. Authorized providers may place patients in observation status when the following requirements are met:

a. Written orders prepared for placement in observation status.

b. Documentation prepared addressing diagnosis or reason for placement in observation status.

c. Written orders prepared for patient care and other therapeutic interventions during the anticipated observation stay.

6. Patient management. Observation status is appropriate for all types of patients for whom the medical and nursing care requirements necessitate monitoring and evaluation for short durations. A registered nurse will be responsible and accountable for nursing care delivered. Some examples of patients routinely treated in observation status are: rule out myocardial infarction; renal colic; rule out appendicitis; and acute asthma.

7. Types of patients and services which will not be classified as outpatient observation include: patients considered critical or unstable; psychiatric or depressed patients; patients with diabetic ketoacidosis; and unconscious patients. Paragraph 11 contains examples of services which cannot be billed as observation care.

8. Medical Records.

a. Documentation of observation care must meet the standards for a short-term stay and must comply with current JCAHO documentation standards. Medical forms in Army Regulation 40-66, Medical Records Administration, or locally devised forms are authorized for use in observation records. At a minimum, the documentation in the medical record will include:

(1) Observation cover sheet to document completion of the extended ambulatory record (EAR).

(2) Privacy Act Statement.

(3) Significant medical history and results of physical examination (Abbreviated Medical Record, Standard Form 539).

(4) Doctors Orders.

(5) Progress notes which will reflect periodic patient assessment, monitoring any interventions performed, and final disposition.

(6) Emergency Care and Treatment Record, if appropriate.

(7) All diagnostic reports; e.g., laboratory, radiology, or electrocardiogram.

(8) Patient education, release instructions, and plan for follow-up care.

(9) Advance medical directives.

b. All documentation related to an observation stay will be filed in a separate treatment record referred to as an EAR. Medical documentation will not be integrated into the health record (HREC), outpatient treatment record (OTR), or inpatient record, except for copies of pertinent summary information, as follows:

(1) Release note with a summary of pertinent diagnostic findings.

(2) Status of patient upon release.

(3) Release instructions with plans for follow-up care.

c. Extended Ambulatory Record.

(1) The EAR will contain all observation and ambulatory procedure visit (APV) records related to the individual in one medical record jacket. A policy to establish this type of record as a formal category of records distinct from the outpatient and inpatient records is currently in development by the OASD(HA).

(2) In cases where the patient is released from observation status to an APV, the observation medical record documentation becomes part of the APV record.

(3) All documentation related to the observation visit will be maintained in the EAR unless the patient is admitted to inpatient status directly from the observation unit. In this circumstance, all data pertaining to the observation visit will become an integral part of the inpatient record for that admission.

(4) The EAR will be filed in the inpatient records room or in a limited access area in conjunction with any inpatient records. Upon request for any inpatient records, the EAR will also be provided.

(5) Completion of Medical Record. A system for reviewing and ensuring appropriate completion of the observation/EAR will be implemented at each MTF.

(6) Medical Records Retirement. The retirement process for inpatient records will apply to the EAR. Records will be retired to the National Personnel Records Center in accordance with applicable regulations; e.g., Army Regulation 25-400-2, The Modern Army Record Keeping System.

9. Evaluation and management (E&M) codes will be used to document the length and acuity of observation care services on the Ambulatory Data System (ADS) form. Observation E&M codes relate to the calendar day (date) the patient spends in observation status and the acuity of services required during the episode of care. Only one E&M code per observation patient will be recorded according to the number of calendar days (up to three) that the patient was under observation care (refer to Table 1).

a. If a patient is placed under and released from observation care on the same date of service, report the appropriate code based upon the acuity of care rendered from the series (99234-99236) for Observation Care.

b. If a patient is placed under observation care on Day 1 and released on Day 2, report the appropriate code (based on acuity of care rendered) from the code series for Initial Observation Care (99218-99220) when released on Day 2.

c. If a patient is placed under observation care on Day 1, stays under observation care through Day 2, and is released from observation care on Day 3, report only code (99217) for Observation Care Discharge on Day 3.

d. If a patient is admitted from observation status, the admission will be noted on the ADS form with the 99221-99223 E&M codes, based upon acuity.

Table 1

LENGTH OF OBSERVATION (CALENDAR DAYS OR DATES)	DAY OF SERVICE	OBSERVATION E&M CODES FOR ACUITY			OTHER E&M CODES FOR OBSERVATION STATUS
		Low	Medium	High	
Observation care services provided within one calendar day (same date)	Day 1	99234	99235	99236	
Observation care services provided over a period of two calendar days (two dates) with release on Day 2	Day 2	99218	99219	99220	
Observation care services provided over a period of three calendar days (three dates) with release on Day 3, not exceeding 48 total hours	Day 3				99217
Admitted from observation status		99221	99222	99223	

e. These observation E&M codes only apply to observation care services as outlined in the attached definition. These codes may not be used for post-operative recovery if the procedure is considered part of a surgical "package" such as APVs or for observation services provided following an inpatient admission.

10. Meals. Any nourishment provided incidental to observation care services is provided as an oral challenge to evaluate the patient's re-establishment of normal physiological response or function as a precondition of release. Observation patients will not be charged the daily inpatient hospitalization (which includes charge for subsistence) rate.

11. Workload Accountability.

a. There are two Medical Expense and Performance Reporting System (MEPRS) codes that must be applied to capture the workload associated with a patient in observation status.

b. The B**0 coding schema indicates the specialty of the care being provided to the observation care patient. For example, observation services performed by an Internal Medicine provider (MEPRS account BAA) would be reported as BAA0. The fourth level code of Ambulatory Nursing Services (DGE*) indicates the area(s) designated for observation care services. This methodology minimizes system changes and implementation costs and allows DOD MTFs to bill for these services beginning Fiscal Year 1999.

c. MTFs will add the B**0 and designated fourth level DGE* observation codes to their Account Subset Definition (ASD) and create these work centers through the Composite Health Care System (CHCS) Patient Appointment and Scheduling (PAS) Module and/or Managed Care Program (MCP) modules.

d. Scheduling for an observation patient will be performed by using B**0 as the requesting MEPRS code in the PAS module of the CHCS as a count visit. The current scheduling procedures will be used to generate an ADS form for processing observation patients. Because there is no observation status on the ADS form at this time, B**0 would appear as if it were any other clinic. Once the patient is scheduled and sent to the area designated for observation care (ward or clinic), minutes of service must be accumulated manually and reported under DGE* (site-specific fourth level codes assigned for observation).

e. The minutes of service and number of patients by clinical specialty under DGE* may be collected by building an ad hoc report in the CHCS to track each patient from the time of the appointment through disposition when completing end-of-the-day processing transactions. Minutes of service and number of patients by clinical specialty will be the dual performance factors reported in MEPRS. This data, as well as the costs associated with these services, will be used to further refine the observation care billing rates.

(1) Nursing Workload

(a) The MEPRS Ancillary Service (DGE*) will be used to capture nursing hours and expenses associated with the care of a patients in observation status.

(b) The first three digits (DGE*) of the MEPRS code identify that this is ambulatory nursing service workload. The fourth digit identifies the unit in which the care is being provided.

(2) Performance factors for this account are number of patients and minutes of service.

f. Provider Workload. The MEPRS Ambulatory Care B**0 will be used to capture provider workload and the costs associated with the care of a patient in observation status.

12. Billing Procedures for the Third Party Collection Program (TPCP).

a. Observation patients with other health insurance will be billed using the TPCP rate established for observation status by the DOD. For billing of observation care services, the Uniform Business Office (UBO) staff will report the number of hours in the units' field (Block #46 of the UB 92). Begin counting minutes of service when the patient is placed in the observation bed and round to the nearest hour. If necessary, verify the minutes of service in the nurses' notes. For example, a patient who was placed in an observation bed at 1503 p.m. according to the nurse's notes and discharged to home at 2145 p.m. will have a "7" placed in the units field. Use the following revenue code on the UB92 billing form:

Revenue Code	Description
762	Observation care services

b. When a patient is admitted from observation status, the ADS form must be forwarded to the UBO for the admission information and minutes of service to be incorporated into the inpatient billing record. The UBO staff will manually calculate observation costs for minutes of service and add the amount to the inpatient DRG bill when it is generated.

c. The following services are not covered by insurance companies and will not be billed as outpatient observation services:

(1) Observation services which exceed 24 hours unless an exception based upon medical necessity is deemed necessary by the provider and is documented in the progress notes.

(2) Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, his or her family, or a physician (e.g., following an uncomplicated treatment or procedure; physician busy when patient is physically ready for discharge; patient awaiting transportation).

(3) Services provided to an inpatient.

(4) Services associated with APVs.

(5) Services provided to patients undergoing diagnostic testing in an outpatient department.

(6) Observation concurrent with treatments such as chemotherapy.

(7) Services for postoperative monitoring.

(8) Any substitution of an outpatient observation service for a medically appropriate inpatient admission.

(9) Services which were ordered as inpatient services by the admitting physician, but reported as outpatient observation services by the hospital.

(10) Standing orders to provide observation care following outpatient services.

(11) Patients discharged to outpatient observation status after an inpatient hospital admission.

13. Questions or concerns related to these instructions should be directed to Headquarters, MEDCOM, Office of the Assistant Chief of Staff for Health Policy and Services. Our points of contact are LTC Oliver, DSN 471-6113; Commercial (210) 221-6113 or COL Dickinson, DSN 471-6616; Commercial (210) 221-6616.

FOR THE COMMANDER:

KEVIN C. KILEY
Brigadier General, MC
Deputy Chief of Staff for
Operations, Health Policy
and Services

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

TRICARE
MANAGEMENT
ACTIVITY

MAR 17 1999

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Interim Policy for the Reporting and Billing of Observation Care Services

This memorandum implements an interim policy for the reporting and billing of observation care services. Attached is the Department of Defense (DoD) definition for observation care services, which is the basis for the release of this interim policy. Effective Fiscal Year 1999 (FY99), all Military Treatment Facilities (MTFs) shall establish B**0 and fourth level DGE* codes to capture workload and expenses for observation care services. The "**" coding schema, which is the same one used for Ambulatory Procedure Visits (APVs), indicates the specialty of care being provided to the observation care patient. For example, observation services performed by an Internal Medicine provider (MEPRS account BAA) would be reported as BAA0. The fourth level code of Ambulatory Nursing Services (DGE*) indicates the area(s) designated for observation care services. This methodology minimizes system changes and implementation costs and allows DoD MTFs to bill for these services beginning FY99.

Observation care services, as outlined in the attached definition, are those services furnished by a hospital on the hospital's premises, including the use of a bed and periodic monitoring by the hospital's nursing or other staff, that are reasonable and necessary to evaluate an outpatient's condition or determine the need for a possible admission to the hospital as an inpatient. Such services are covered only when provided by the order of a physician or another individual authorized to admit patients to the hospital or to order outpatient tests. Most observation care services do not exceed one day. Some patients may require a second day of services. Only in rare and exceptional cases do observation services span more than two calendar days.

MTFs will add the B**0 and designated fourth level DGE* observation codes to their Account Subset Definition (ASD) and create these work centers through the Composite Health Care System (CHCS) Patient Appointment and Scheduling (PAS) Module and/or Managed Care Program (MCP) modules. Scheduling for an observation patient will be performed by using B**0 as the requesting Medical Expense and Performance Reporting System (MEPRS) code in the PAS module of CHCS as a count visit. The current scheduling procedures will be used to generate an Ambulatory Data System (ADS) form for processing observation patients. Since

there is no Observation status on the ADS form at this time, B**0 would appear as if it were any other clinic. Once the patient is scheduled and sent to the area designated for observation care (ward or clinic), minutes of service must be accumulated manually and reported under DGE* (site-specific fourth level codes assigned for observation). The minutes of service under DGE* may be collected by building an ad hoc report in CHCS to track each patient from the time of the appointment through discharge when completing end-of-the-day processing transactions. Minutes of service and number of patients under DGE* will be the dual performance factors reported in MEPRS. This data, as well as the costs associated with these services, will be used to further refine the observation care billing rates.

When registering an observation patient, the observation encounter will be on the Service/MTF specific Authorization and Treatment Statement. Patient registration would also include the Other Health Insurance (OHI) data on a DD2569 form – Third Party Collection Program/Insurance Information.

Evaluation and Management (E&M) codes will be used to document the length and acuity of observation care services on the ADS form. Observation E&M codes relate to the calendar day (date) the patient spends in observation status and their acuity. **Only one** E&M code per observation patient will be recorded, according to the number of days (up to three) that the patient was under observation care.

- If a patient is placed under and released from observation care on the same date of service, report the appropriate code from the series (99234–99236) for Observation Care.

- If a patient is placed under observation care on Day 1 and released on Day 2, report the appropriate code from the code series for Initial Observation Care (99218–99220) when released on Day 2.

- If a patient is placed under observation care on Day 1, stays under observation care through Day 2, and is released from observation care on Day 3, report only code (99217) for Observation Care Discharge on Day 3.

- If a patient is admitted from observation, the admission will be noted on the ADS form with the 99221-99223 E&M codes, as appropriate. The ADS form must be forwarded to the Uniform Business Office (UBO) for the admission information and minutes of service to be incorporated into the inpatient billing record. The UBO staff will manually calculate the observation costs for minutes of service and add the amount to the inpatient DRG bill when it is generated.

Any nourishment provided incidental to observation care services is provided as an oral challenge to evaluate the patient's re-establishment of normal physiological response or function as a precondition of release. The observation nourishment rate will be calculated in the same manner as that currently used for APVs.

The following table summarizes the information described above:

LENGTH OF OBSERVATION (CALENDAR DAYS OR DATES)	DAY OF SERVICE	OBSERVATION E&M CODES FOR ACUITY			OTHER E&M CODES FOR OBSERVATION STATUS
		Low	Medium	High	
Observation care services provided within one calendar day (same date)	Day 1	99234	99235	99236	
Observation care services provided over a period of two calendar days (two dates) with release on Day 2	Day 2	99218	99219	99220	
Observation care services provided over a period of three calendar days (three dates) with release on Day 3, not exceeding 48 total hours	Day 3				99217
Admitted from observation status		99221	99222	99223	

These observation E&M codes only apply to observation care services as outlined in the attached definition. These codes may not be used for post-operative recovery if the procedure is considered part of a surgical "package" such as APVs. Also observation services after an inpatient admission are not covered. Refer to the attached definition that also specifies other services not classified as observation care services.

After the patient is discharged from observation care services, a copy of the completed ADS form and minutes of service (which may be collected on an ad hoc report from CHCS or manually) will be submitted manually to the Uniform Business Office (UBO) on a daily basis for billing. Until billing for observation care services is incorporated into DoD automated information systems, MTFs will bill manually. It is important that the UBO receive copies of all forms documenting workload of observation care services for billing purposes.

For billing of observation care services, the UBO staff will report the number of hours in the units' field (Block #46 of the UB 92). Begin counting minutes of service when the patient is placed in the observation bed and round to the nearest hour. If necessary, verify the minutes of service in the nurses' notes. For example, a patient who was placed in an observation bed at 3:03 p.m. according the nurse's notes and discharged to home at 9:45 p.m. will have a "7" placed in the units field. Use the following revenue code on the UB92 billing form:

Revenue Code	Description
762	Observation care services

All documentation related to an observation stay will be filed in a separate treatment record (see the note below). The medical documentation will not be integrated into the health record (HREC), outpatient treatment record (OTR), or inpatient record, except for copies of pertinent summary information, as follows:

(1) Release note with a summary of pertinent diagnostic findings

(2) Status of patient upon release

(3) Release instructions with plans for follow-up care

NOTE: This separate treatment record will be called the Extended Ambulatory Record (EAR). The EAR will contain all APV and observation records related to the individual in one medical record jacket. A policy to establish this type of record as a formal category of records distinct from the outpatient and inpatient records is currently in development.

In cases where the patient is released from observation status to an APV, the observation medical record documentation becomes part of the Extended Ambulatory Record (EAR). In addition, a copy of pertinent summary information from the observation and APV episodes will be filed in the patient's outpatient treatment or health record, as described above, in accordance with appropriate Service regulations.

The treatment record will be filed in the inpatient record room or in a limited access area in conjunction with any inpatient records. The retirement process for inpatient records will apply to the EAR. Records will be retired to the National Personnel Records Center in accordance with applicable regulations.

Service MEPRS and UBO Program Managers should provide a copy of their implementation plans to TRICARE Management Activity, Resource Management, Financial Analysis and Integration, by April 23, 1999. For further information, the point of contact for this policy is Major Rose Layman. She may be reached at (703) 681-8910, extension 1007 or via email at Rose.Layman@tma.osd.mil.

H. James T. Sears, M.D.
Executive Director

Attachment:
As stated

OFFICE OF THE ASSISTANT SECRETARY OF DEFENSE
HEALTH AFFAIRS
SKYLINE FIVE, SUITE 810, 5111 LEESBURG PIKE
FALLS CHURCH, VIRGINIA 22041-3206

TRICARE
MANAGEMENT
ACTIVITY

JUL 7 1998

MEMORANDUM FOR SURGEON GENERAL OF THE ARMY
SURGEON GENERAL OF THE NAVY
SURGEON GENERAL OF THE AIR FORCE

SUBJECT: Department of Defense Observation Services Definition

The Military Health System, like its civilian counterparts, is using observation beds/services to determine the need for further outpatient treatment or for inpatient admission. The Department had no definition for observation services and as a consequence, was not billing third party payers for patients occupying observation beds. The following definition was aligned as closely as possible with the existing Health Care Financing Administration observation services definition and is now the DoD standard. This definition will allow the Department of Defense (DoD) to define the business rules necessary to bill third party payers for appropriate observation services.

1. Outpatient Observation Services.

Observation services are those services furnished by a hospital [*the term "hospital" includes DoD clinics with resources to provide these services*] on the hospital premises, including the use of a bed and periodic monitoring by a hospital's nursing or other staff, which are reasonable and necessary to evaluate an outpatient's condition or determine a possible admission to the hospital as an inpatient. Such services apply to Observation Patients only when provided by order of physician or another individual authorized by hospital staff bylaws to admit patients to the hospital or order outpatient tests. Most observation services do not exceed 23 hours. However, in some instances, depending on medical necessity, up to 48 hours of observation services may be justified. The period of observation begins the moment the patient is placed in observation status.

Observation patients may be cared for in either dedicated observation units or in designated bed space on inpatient units. Appropriate Joint Commission on Accreditation of Healthcare Organizations standards will apply.

2. Coverage of Outpatient Observation Services.

Generally, a person is considered a hospital inpatient if formally admitted as an inpatient with the expectation that he or she will remain at least overnight. When a patient is placed in observation status, but has not been formally admitted as an inpatient, the patient initially is treated as an outpatient. The purpose of observation is to determine the need for further

HPAEC 1007

treatment or for inpatient admission. Thus, a patient in observation may improve and be released, or be admitted as an inpatient. If a patient is retained on observation status for more than 48 hours without being admitted as an inpatient, further observation services will not be considered reasonable and necessary for the diagnosis or treatment of illness or injury or to improve the functioning of a malformed body member. A maximum of 48 hours of observation may be reimbursable.

3. Notification of Beneficiary.

If you intend to place or retain a beneficiary in observation for a non-covered service, you must give the beneficiary proper written advance notice of non-coverage under limitation on liability procedures.

4. Services which will not be classified as Outpatient Observation.

The following services are not covered as outpatient observation services:

a. Observation services which exceed 24 hours unless an exception is deemed necessary following a medical necessity review.

b. Services which are not reasonable or necessary for the diagnosis or treatment of the patient but are provided for the convenience of the patient, his or her family, or a physician (e.g., following an uncomplicated treatment or procedure; physician busy when patient is physically ready for discharge; patient awaiting placement in a long-term care facility).

c. Inpatient services.

d. Services associated with ambulatory procedure visits.

e. Routine preparation services furnished prior to the testing and recovery afterwards. For patients who undergo diagnostic testing in a hospital outpatient department.

f. Observation concurrent with treatments such as chemotherapy.

g. Services for postoperative monitoring.

h. Any substitution for an outpatient observation service for a medically appropriate inpatient admission.

i. Services which were ordered as inpatient services by the admitting physician, but reported as outpatient observation services by the hospital.

j. Standing orders for observation following outpatient services.

k. May not be discharged to outpatient observation status after an inpatient hospital admission.

5. Implementation.

a. Observation begins when the provider writes the order to place the patient in observation status.

b. Units will be measured in hours and minutes.

c. Patient acuity needs to be accounted for, by the provider.

d. Admissions as a result of observation will date the admission from the start of observation, but only if the patient remains at the same facility. When patients are transferred from the observation facility to another hospital, the observation remains with the original facility.

If you have any questions or concerns, please contact Mr. James Johnston at (703) 681-6918.

H. James T. Sears, M.D.
Executive Director

cc:
DASD, C&PP
DASD, HB&FP
DASD, HOP
DASD, P&EA
DIR, IMT&R
DIR, RM
PRESIDENT, USUHS